

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10089

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09979

1. DECEASED-NAME (Type or Print) JOSEPH THOMAS HIGGS			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month July Day 30 Year 1968			2b. HOUR OF DEATH 9:45 P.M.		
3. SEX Male	4. RACE White	5. DATE OF BIRTH July 1, 1921	6. AGE (in years last birthday) 47 YRS	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	2c. DATE PRONOUNCED DEAD Month July Day 30 Year 1968	2d. HOUR 9:45 P.M.	
7a. BIRTHPLACE (State or foreign country) Woodstock, Md		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Howard		
10. CITY OR TOWN OF DEATH Ellicott City		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Truck Driver			12b. KIND OF BUSINESS OR INDUSTRY Lumber
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 127 Fels Ave.
14. FATHER'S NAME First Middle Last William Thomas Higgs				15. MOTHER'S MAIDEN NAME First Middle Last Sarah E. Howard				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16b. SOCIAL SECURITY NO. (If yes give year or dates of service) WW II 214-14-0129		17. INFORMANT ADDRESS Mrs. Hazel F. Higgs, Ellicott City, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109 (b) Arteriosclerotic Cardio Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min. 1 year								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type) George E. Burgtorf		M.D. George E. Burgtorf M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, or County) Church Road, Ellicott City, Md.		22b. DATE SIGNED 7-31-1968		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8-2-1968		23c. NAME OF CEMETERY OR CREMATORY Good Shepherd		23d. LOCATION (City or Town) (County) (State) Ellicott City, Md.		
24. FUNERAL DIRECTOR Higinbotham-Slack Funeral Home				ADDRESS Ellicott City, Md		25a. REC'D BY REGISTRAR DATE AUG 2 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO THE HONORABLE CHIEF OF BUREAU OF LANDS
WASHINGTON, D. C.

SIR:

I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above captioned matter.

The Bureau of Land Management is at present unable to furnish the information requested in your letter.

Very respectfully,
S. H. HARRIS, Chief of Bureau

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 99980
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last SISTER ALIX (FRANCES) KEARY			2a. DATE OF DEATH Month Day Year JULY 15 1968			2b. HOUR 8:45 AM	
3. SEX F		4. RACE W		5. DATE OF BIRTH SEPT. 24, 1885		6. AGE (In years last birthday) 84 YRS.	
7a. BIRTHPLACE (State or foreign country) IRELAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HOWARD Md.	
10. CITY OR TOWN OF DEATH MARRIOTTSVILLE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BON SECOURS INF		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RELIGIOUS		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY HOWARD		13c. CITY OR TOWN MARRIOTTSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER MARRIOTTSVILLE, RD.							
14. FATHER'S NAME First Middle Last MARTIN KEARY			15. MOTHER'S MAIDEN NAME First Middle Last ANNE KILLEN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 219-54-5728		17. INFORMANT Address A. Mary Alberte - Marriottsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ischemic Thrombosis 1519 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 HRS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 151X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from July 10, 1966 to July 10, 1968 , that (I) (we) last saw the deceased alive on July 10, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE JAN L. DORR		22c. DATE SIGNED 7/15/68		22d. PHYSICIAN'S NAME (Type) JAN L. DORR			
22e. ADDRESS 4804 PROSPERITY AVE		22f. ADDRESS 4804 PROSPERITY AVE					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7-17-68		23c. NAME OF CEMETERY OR CREMATORY Cathedral Cms.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Farley Cunningham		ADDRESS 4804 PROSPERITY AVE		25a. RECD BY REGISTRAR JUL 19 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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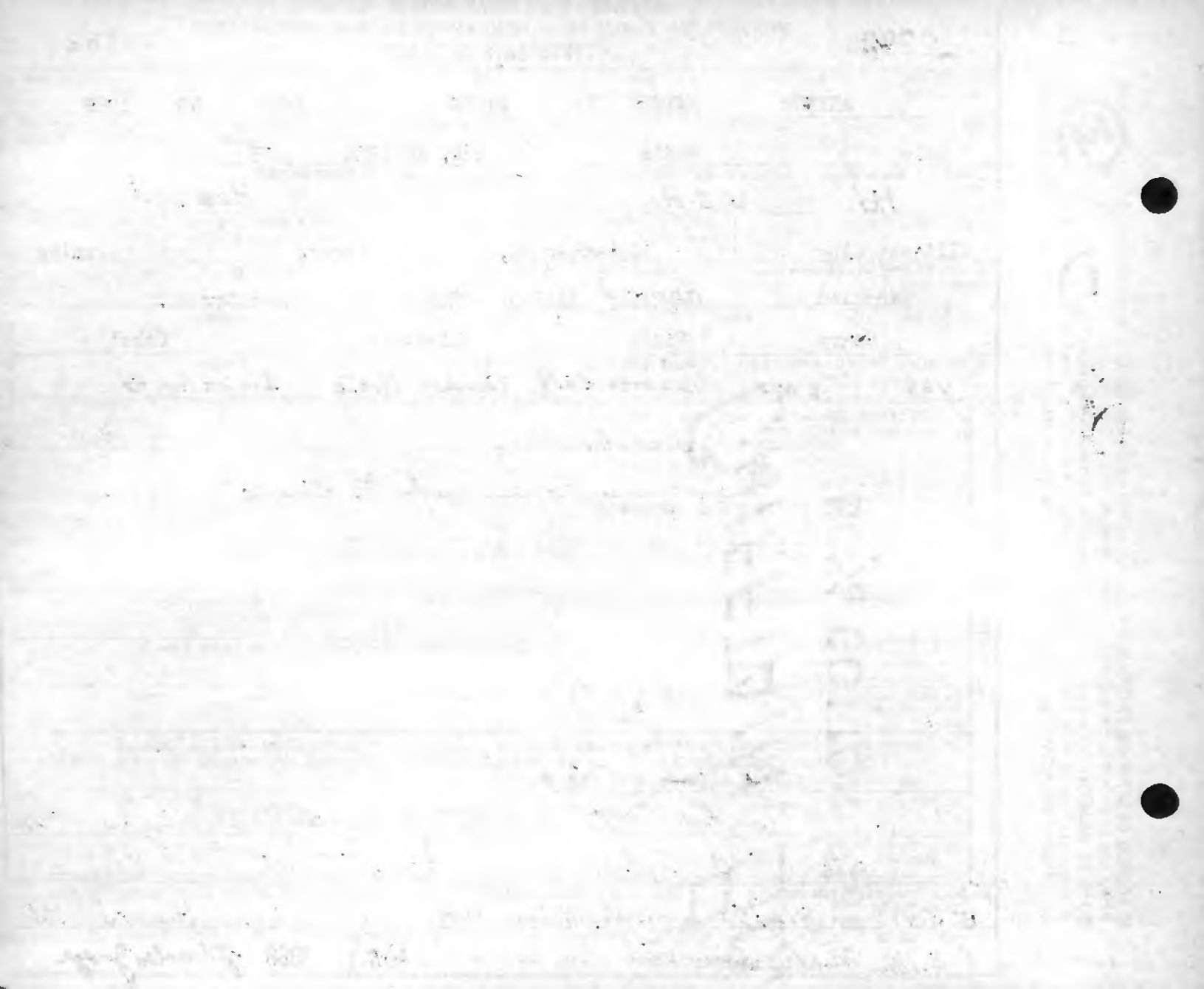
MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last ANNA LENORE MEYER						2a. DATE OF DEATH Month Day Year July 30 1968			2b. HOUR 904 M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH July 15, 1898		6. AGE (In years last birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Poland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HOWARD Md.						
10. CITY OR TOWN OF DEATH EIK Ridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5600 Washington Blvd.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife			12b. KIND OF BUSINESS OR INDUSTRY AT-HOME			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md				13b. COUNTY Howard		13c. CITY OR TOWN EIK Ridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 5600 Washington Blvd		
14. FATHER'S NAME First Middle Last SAMUEL MURTENBAUM				15. MOTHER'S MAIDEN NAME First Middle Last DENN LAMPERT								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address Paul D Meyer M.O 5600 Washington Blvd EIK Ridge Md						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) CARDIO Pulmonary Failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs		
DUE TO, OR AS A CONSEQUENCE OF												
(b) CARCINOMATOSIS										6 years		
DUE TO, OR AS A CONSEQUENCE OF												
(c) Carcinoma of the breast												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
170 X												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from JAN , 19 63 , to July , 19 68 , that (I) (we) last saw the deceased alive on 20 July , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Paul Donald Meyer M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 30 July 68				
22d. PHYSICIAN'S NAME (Type) PAUL DONALD Meyer						22e. ADDRESS 803 CATHARTIC ST. 21202 City						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 8-1-68		23c. NAME OF CEMETERY OR CREMATORY OHEL YAKOV				23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND				
24. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD						25a. REC'D BY REGISTRAR AUG 2 1968		25b. REGISTRAR'S SIGNATURE Charles J. J...				

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MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print)				First		Middle		Last		2a. DATE OF DEATH				2b. HOUR	
ARTHUR				WALTER		MINTZ		July 29 1968				M			
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
male		white		Oct. 10 1894				73		MONTHS		DAYS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH									
Md.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		HOWARD									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
Ellicott City				Ilchester Rd.				farmer				Farming			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Maryland				HOWARD		Ellicott City		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Ilchester Rd.					
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME					
Henry				Mintz				Elizabeth		Gabel					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT				Address					
Yes				WWI		220-46-8379 Theodore MINTZ				Ilchester Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>Cardiac dysrhythmia</u>												1946.			
DUE TO, OR AS A CONSEQUENCE OF															
(b) <u>Emphysema, chronic; nephritis, chronic</u>															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
5271															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				HOUR A.M. Month Day Year											
				P.M. 19											
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>															
22a. I certify that (I) (this hospital) attended the deceased from <u>July 23, 1968</u> , to <u>July 29, 1968</u> , that (I) (we) lost the deceased alive on <u>July 29, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE				DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED					
Robert B Taylor MD										July 30, 1968					
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS											
ROBERT B. TAYLOR				Ellicott City				Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
BURIAL				8/1/68		Meadow Ridge Cem.				Howard Md					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
E. S. Mac Nabb				Catonville Md 21220				DATE AUG 1 1968		J. Charles Judge					



FOR STATE HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/>			2b. HOUR 12:15 P.M.
STEPHEN ROBERT MULLIGAN						7-25-68			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.	2c. DATE PRONOUNCED DEAD Month 7 Day 25 Year 19 68	2d. HOUR 12:55 P.M.
Male	White	5-29-68	0 YRS	2	4				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HOWARD			
MARYLAND		USA							
10. CITY OR TOWN OF DEATH GLENWOOD			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ROXBURY MILL RD.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NONE (INFANT)			12b. KIND OF BUSINESS OR INDUSTRY NONE
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY HOWARD		13c. CITY OR TOWN GLENWOOD	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER ROXBURY MILL ROAD		
14. FATHER'S NAME First Middle Last JAMES MARTIN MULLIGAN			15. MOTHER'S MAIDEN NAME First Middle Last TRENNIA ANN EMERY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS MED. RECORD DEPT. MONTGOMERY GENERAL HOSP.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>due to Asphyxiation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>(SDII)</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>9240</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year 1 HOUR A.M. 7-25 19 68 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <u>Infant supported in crib</u>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Home</u>		21f. LOCATION Street or R.F.D. No. City or Town <u>Roxbury Mill Rd. Glenwood</u>		County State <u>Howard Md</u>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Belden R. Reap</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <u>July 25, 1968</u>			
EXAMINER'S NAME (Type) BELDEN R. REAP, M. D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (City, Town, County) <u>Robertson</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE <u>7-27-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wm Lees Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>			
24. FUNERAL DIRECTOR <u>Harry W. Haight</u>			ADDRESS <u>Sylvanville, Md.</u>			25a. REC'D BY REGISTRAR DATE <u>JUL 30 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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10094

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09984

1. DECEASED-NAME (Type or print) Ferdinand Oswald Soot			2a. DATE OF DEATH Month 7 Day 20 Year 68			2b. HOUR 9:30 PM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH Sept. 8, 1904		6. AGE (In years last birthday) 63 YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Estonia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Howard Md.				
10. CITY OR TOWN OF DEATH Ellicott City			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 823 W. Stayman Drive			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Carpenter			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d. STREET AND NUMBER 6311 Pioneer Drive	
14. FATHER'S NAME First Juhan Middle Soot Last Soot			15. MOTHER'S MAIDEN NAME First Johanna Middle Asserus Last Asserus							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 213-30-8521			17. INFORMANT Anita Soot			Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma 185X DUE TO, OR AS A CONSEQUENCE OF (b) carcinoma, prostate DUE TO, OR AS A CONSEQUENCE OF (c) 177X Rheumatic heart									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 months 2 1/2 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 177X Rheumatic heart										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 5-16-1968 to 7-20-1968 , that (I) (we) last saw the deceased alive on 7-7-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Paul H. Anniko DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 7/22/68				
22d. PHYSICIAN'S NAME (Type) Paul H Anniko M.D.						22e. ADDRESS 3800 Erdman Ave				
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 7/24/68			23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR ADDRESS Leonard J Ruck Inc. Balto. Md.						25a. REC'D BY REGISTRAR DATE JUL 22 1968			25b. REGISTRAR'S SIGNATURE [Signature]	

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MAINT IS DRAFTED

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Handwritten notes on lined paper, including the date 10/20/01 and the phrase "MAINT IS DRAFTED".

Vertical text on the right margin, possibly a date or reference number.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit should be removed from the certificate and placed in the funeral home. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <i>James E. Wilder</i>						2a. DATE OF DEATH <i>July 26 1968</i>			2b. HOUR <i>4:00 AM</i>		
3. SEX <i>MALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>JAN 3 1981</i>		6. AGE (In years last birthday) <i>87</i> YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>TENN.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Howard</i> Md.					
10. CITY OR TOWN OF DEATH <i>Ellicott City</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Tridelphia Rd</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>FARMER</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>				13b. COUNTY <i>Howard</i>		13c. CITY OR TOWN <i>Ellicott City</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Tridelphia Rd</i>	
14. FATHER'S NAME First <i>William</i> Middle <i>Wilder</i> Last <i>Wilder</i>				15. MOTHER'S MAIDEN NAME First <i>MARVERIA</i> Middle <i>Lamb</i> Last <i>Lamb</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown? <i>NO</i> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <i>213-26-2845</i>		17. INFORMANT <i>DEE WILDER</i>		Address <i>WOODSTOCK, MD</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure, A.S.H.D.</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Brain Syndrome</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Head infection - bronchial pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1963</i> <i>2-26-68</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4200</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>1963</i> , 19 <i>7-26</i> , to <i>2-26</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>7-26-1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Howard E. Hall</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>7-29-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Liberty Baptist</i>		23d. LOCATION (City or Town) <i>Lisbon</i> (County) <i>Howard</i> (State) <i>MD</i>					
24. FUNERAL DIRECTOR <i>Higinbotham-Slack</i> ADDRESS <i>Ellicott City, MD</i>						25a. REC'D BY REGISTRAR DATE <i>JUL 30 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

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